

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012374

STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 383

FILED APR 20 1959

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 122 Deer		d. STREET ADDRESS (If outside, give location) 122 Deer	
3. NAME OF DECEASED (Type or print) First Middle Last Herman Gross		4. DATE OF DEATH Month Day Year April 13, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1868
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Re Laborer		10b. KIND OF BUSINESS OR INDUSTRY Swift & Co	11. BIRTHPLACE (City and state or country) Miami Co, Kansas
13a. FATHER'S NAME August Gross		13b. MOTHER'S MAIDEN NAME Eleanora Buck	14. NAME OF HUSBAND OR WIFE Jay Gross
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no no		16. SOCIAL SECURITY NO. 496-07-6002	17. INFORMANT Mrs. Pearl Allen St. Joseph, Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH Unk.
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 6/22/56 to 4/13/59 and last saw him alive on 4/12/59 Death occurred at 8:45 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Collis Rounly MD		22b. ADDRESS Social Welfare Board 10th & Olive, St. Joseph, Mo.	
		22c. DATE SIGNED 4/14/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/15/59	
23c. NAME OF CEMETERY OR CREMATORY Old Fellows Public		23d. LOCATION (City, town, or county) (State) St. Joseph, Mo	
24. FUNERAL DIRECTOR J. E. O'Connell		25. DATE RECD. BY LOCAL REG. April 17, 1959	
ADDRESS St. Joseph, Mo		26. REGISTRAR'S SIGNATURE Wm. Clark Goodell	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Dr. Collis Rounly
All diseases in Part I must be causally related.
Doctor, coroner, etc., must use only standard nomenclature in item 18. No symptoms with no listed.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~or by~~, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed

John E. Rupp

Licensed Embalmer No. *3986*

P. O. Address *Joseph*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.